

Supervision in Community Pharmacy Executive Summary to Pharmacy Research UK

submitted February 2013 – revised July 2013

Dr Fay Bradley
Research Associate

Dr Ellen I Schafheutle
Senior Lecturer in Law & Professionalism in Pharmacy

Dr Sarah C Willis
Lecturer in Social Pharmacy

Prof Peter R Noyce
Professor of Pharmacy Practice

Centre for Pharmacy Workforce Studies, Manchester Pharmacy School
The University of Manchester, Oxford Road, Manchester M13 9PT

1 BACKGROUND

Community pharmacies are there to ensure that medicines are effectively and safely dispensed and appropriate advice is given on their use. There is surprising diversity in the operation of community pharmacies internationally. In some countries, all pharmaceutical services are undertaken or closely supervised by the pharmacist in charge (therefore requiring the pharmacist to be on the premises all or most of the time, which is the current situation in the UK) and in others there is much more flexibility in pharmacists exercising their responsibility. This has implications for the pharmacy workforce and skill mix, and the organisation and training of non-pharmacist support staff¹ to deliver community pharmacy services, particularly if pharmacists are to use their clinical skills and expertise more widely. However, little is known about which kinds of pharmacy activities and services may safely be undertaken by pharmacy support staff when a pharmacist is not on the pharmacy premises.

This **study aimed** to investigate current arrangements for supervision, role delegation and skill mix in community pharmacy and to seek stakeholders' perceived risk levels associated with different types of pharmacy activities and services, and views on potential changes to supervision requirements.

2 METHODS

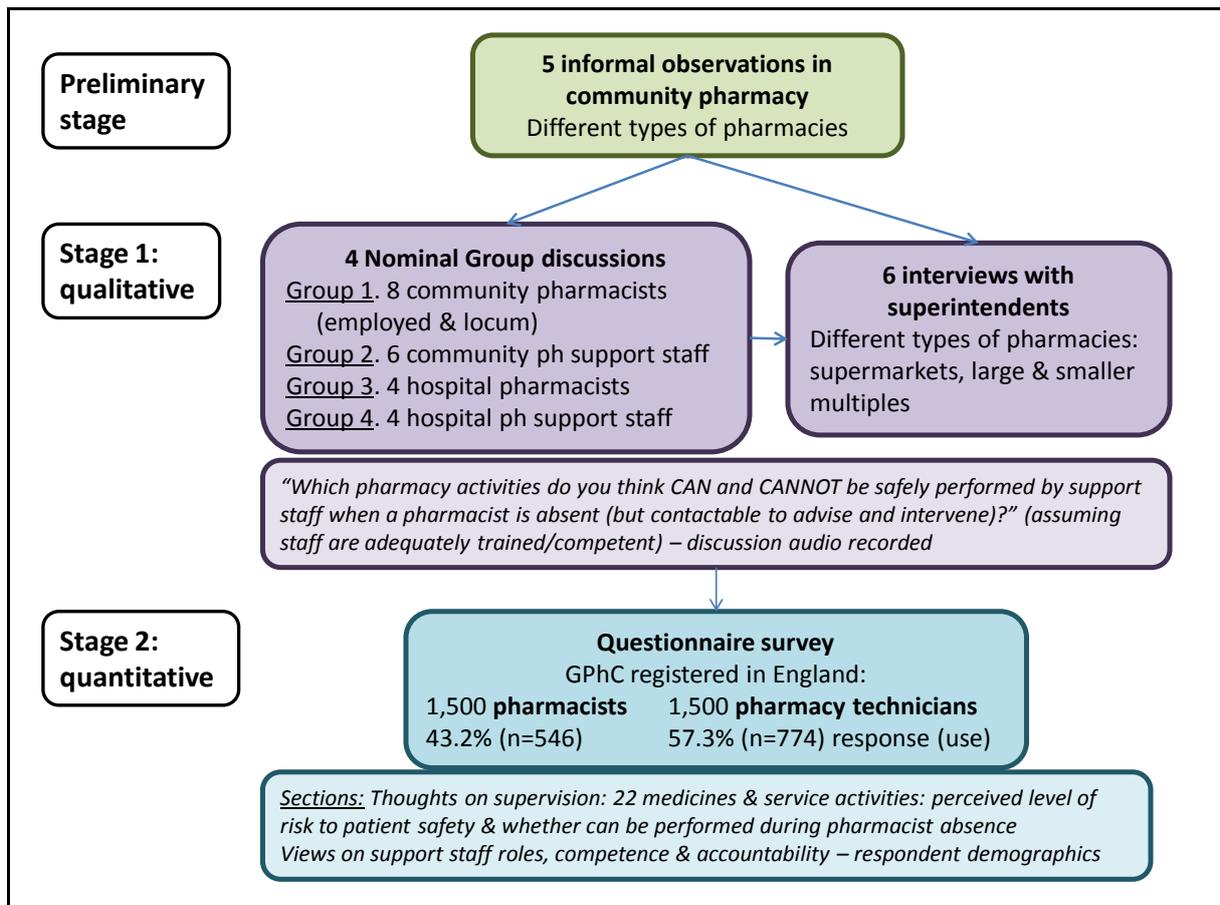
This study employed a mixed methods approach, using qualitative and quantitative methods, thus allowing detailed insights and understanding, as well as providing views from a larger, representative sample of pharmacy professionals. A number of informal observations were undertaken during a preliminary stage of the study ensuring it was firmly grounded in current practice, and alongside a review of the literature, informed the main stages.

Stage 1, the qualitative study element, involved four group discussions using the nominal group technique (NGT), and six one-to-one interviews with superintendent pharmacists. Stage 2, informed by the findings from stage 1, involved a questionnaire survey of a large, representative sample of pharmacists and pharmacy technicians working in England. Both stages were approved by the University of Manchester ethics committee, and the flowchart below shows the study elements and process.

Although the focus of the study was on supervision arrangements in community pharmacy, input from hospital pharmacy staff was also sought, with the aim of providing an insight into how supervision and task delegation works in other settings. Hospital pharmacists commonly deliver clinical services away from the pharmacy, with some activities performed by support staff without direct pharmacist supervision.

¹ 'Pharmacy support staff,' for the purpose of this study, are defined as non-pharmacist staff. They thus include pharmacy technicians as well as dispensing assistants and medicines counter assistants etc.

Study stages & process



3 RESULTS

3.1 Stage 1 – qualitative

The identification and rankings of activities which nominal group participants thought could/ could not be safely performed during a pharmacist’s absence were used to construct a list of 22 activities that survey participants were asked to rank in terms of perceived risk and feasibility of performing them during a pharmacist’s absence in stage 2. These rankings are therefore left for quantitative analysis of stage 2, and consideration is given here in particular to qualitative analysis of discussions which occurred to explain participants’ views and decisions and thus provided valuable insights.

Community pharmacists felt that their presence was critical to safe pharmacy operation, providing the (unsolicited) opportunity for intervention. Reluctance to relinquish control, and concerns about trusting staff, their competencies and ability to recognise their own limitations, were voiced. Hospital pharmacists, with more experience of working away from the dispensary, were more open to certain activities being performed during their absence, particularly if they remained contactable. Taking professional responsibility was a central theme; pharmacists felt that support staff should be

accountable for their own decisions and actions, whilst views amongst support staff varied. Some were unsure about taking responsibility; others (particularly hospital pharmacy technicians) embraced this in the context of being registered professionals.

Overall, the six superintendents interviewed expressed similar views in relation to the need to reform supervision requirements in the future, to enable greater flexibility. All felt that current supervision requirements were in some ways impeding the ability of pharmacists to offer more clinical patient-focused activities. All superintendents stated that community pharmacy's strength was the accessibility of the pharmacist for patients. They were also supportive of utilising the skills and competencies of trained support staff further, in particular those of pharmacy technicians, as registered pharmacy professionals.

3.2 Stage 2 - survey

In all four respondent groups (pharmacists and pharmacy technicians, working in community and hospital pharmacy respectively) there was a strong correlation between the respondents' perceptions of levels of risk to patient safety of support staff performing 22 activities during the pharmacist's absence, and whether they felt that the same 22 activities could be safely performed by suitably qualified and competent support staff during a pharmacist's absence. However, there were clear differences between sectors (community vs. hospital) and role (pharmacist vs. pharmacy technician). Community pharmacists were most reserved when judging which activities they felt their support staff could safely perform during their absence; pharmacy technicians in community and hospital felt significantly more confident performing particularly technical activities, with hospital pharmacists' views more aligned.

3.2.1 Medicines and service related activities

Using variation in respondents' levels of agreement with the extent to which the 22 activities were perceived as being safe to perform by suitably qualified and competent support staff during a pharmacist's absence, activities were grouped as follows into:

1. **'Safe' activities** – where there was general agreement across the four groups that these activities were safe (mean agreement level ≤ 2 for each professional sub-group)²
2. **'Borderline' activities** – activities which did not achieve mean agreement of ≤ 2 from all four professional groups, but did so from at least one
3. **'Unsafe' activities** – which did not achieve a mean agreement of ≤ 2 from any of the professional groups

The following boxes list the activities which were considered 'safe,' 'borderline,' and 'unsafe.' Detailed analysis is presented in the main report, but the key points are summarised here:

²To examine the strength of agreement (or disagreement), a four-point agreement scale was presented to respondents (1=strongly agree, 2=agree, 3=disagree, 4=strongly disagree).

'Safe' activities

1. Take in prescriptions
2. Sell General Sales List (GSL) medication
3. Sign for deliveries of medicines (not CDs)
4. Assemble (without labelling) prescriptions (not CDs)
5. Label prescription items (not CDs)
6. Signposting to other services
7. Provide healthy living advice to patients

Key points

- Perceived risk for these seven 'safe' activities was either no or low risk amongst each professional subgroup, apart from the 'labelling of prescription items' which was on average perceived as representing a relatively higher risk activity by community pharmacists.
- The largest difference in opinion was between community pharmacists and community pharmacy technicians, with a greater proportion of community pharmacy technicians agreeing that these seven activities could be performed by support staff and that the risk level of these was no/low risk. These differences were found to be statistically significant.
- Differences between hospital and community pharmacists, and hospital and community pharmacy technicians were also found and may be explained by the level of familiarity those in different sectors have with these activities.
- Findings suggest that if supervision changes were made to allow support staff to perform more activities during a pharmacist's absence, then **these seven activities could be adopted straightforwardly into a revised model of supervision.**

'Borderline' activities

1. Conduct a smoking cessation consultation
2. Provide health checks (e.g. blood pressure, weight check)
3. Hand out checked and bagged prescriptions (which do not require pharmacist advice or intervention)
4. Dispense established repeat prescriptions (which have already had a previous clinical check)
5. Sell Pharmacy (P) medication following standard operating procedures (if no need for referral /intervention)
6. Accuracy check items, if dispensed by someone else (not CDs)
7. Sign for controlled drug (CD) deliveries
8. Have access to the CD cupboard to put away items
9. Carry out extemporaneous preparation

Key points

- Overwhelmingly, community pharmacists expressed the highest levels of disagreement that these 'borderline' activities could be performed by support staff during their absence.
- Similarly, community pharmacists were the most cautious professional subgroup in relation to their perception of risk.
- On average, hospital pharmacy technicians appear to be the most comfortable and least cautious about performing these activities during a pharmacist's absence, which may be explained by their greater familiarity with these sorts of tasks on a day-to-day basis.
- A lack of consensus across the subgroups regarding 'borderline' activities was found, with greater divergence in opinion between hospital and community pharmacists for these activities. This again may be related to the different types of tasks performed by pharmacy technicians in the hospital sector.
- Hospital pharmacists and hospital pharmacy technicians appear more accepting of these 'borderline' activities than their community pharmacy counterparts. This suggests that there may be lessons that community pharmacy could learn from the supervision arrangements in hospital pharmacy.
- Here, the activities '**handing out checked and bagged prescriptions**', '**dispense established repeat prescriptions**', and '**accuracy checking**' may deserve particular attention, as the only group not in agreement that these activities could be safely performed during a pharmacist's absence were community pharmacists.

'Unsafe' activities

1. Provide a minor ailments service
2. Provide medicines under Patient Group Direction (PGD) (e.g. chloramphenicol, not Emergency Hormonal Contraception)
3. Give patients advice about Prescription Only Medicines (POMs)
4. Give clinical advice to patients
5. Provide New Medicine Service (NMS)
6. Conduct Medicine Use Reviews (MURs)

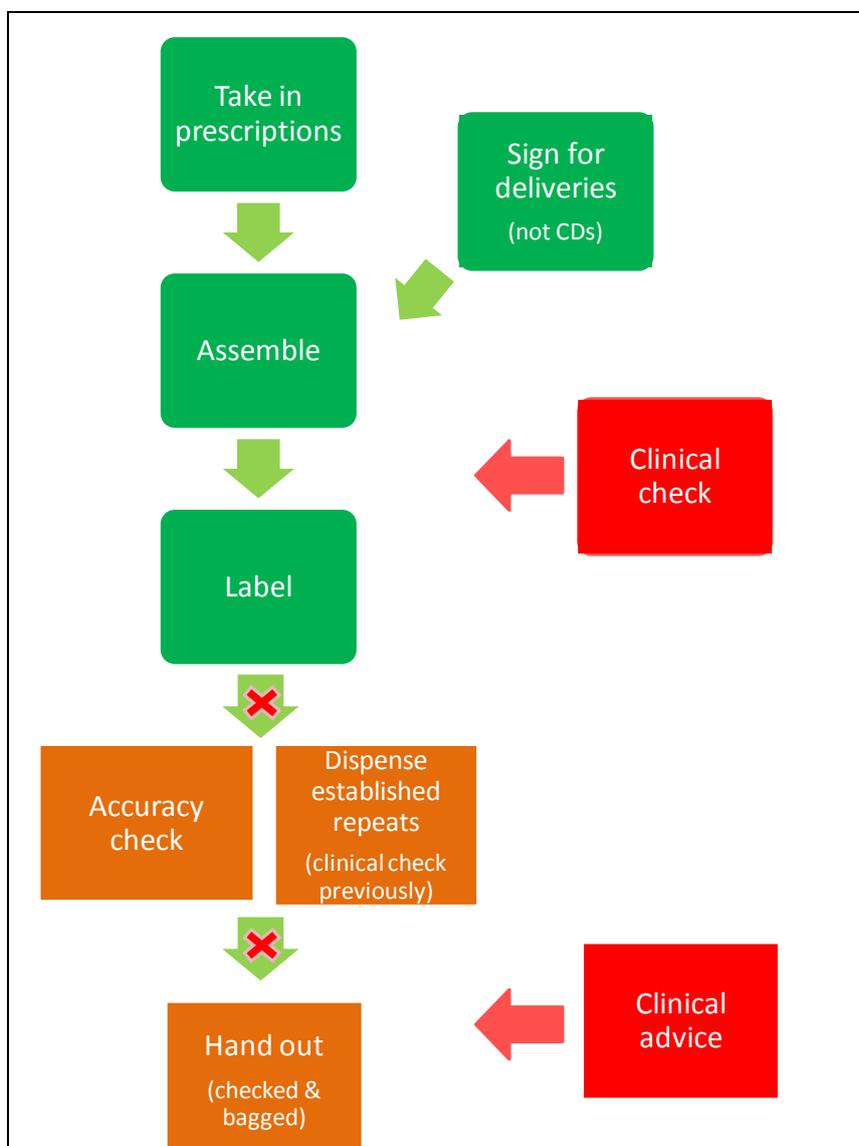
Key points

- Differences between the professionals groups were still seen, with pharmacy technicians from both sectors tending to express more agreement that these activities could be safely performed and lower perceptions of risk during a pharmacist's absence.
- Again, community pharmacists were the most opposed to these activities being performed during a pharmacist's absence.
- However, it could be concluded that as a result of the higher levels of disagreement and risk ratings expressed by respondents, these activities may not be appropriate for support staff to perform during a pharmacist's absence and therefore should not be included in a revised model of supervision.

3.2.2 The dispensing process

This study has divided the dispensing process, which consists of a whole range of activities, and identified those which were considered to be 'safe' to be performed by pharmacy support staff during a pharmacist's absence. This process, and whether activities were considered 'safe' or 'borderline' is depicted in the flow diagram below. This offers specific and evidence based insight into how changes to supervision arrangements could be informed and taken forward. 'Borderline' activities in particular may deserve further attention when considering future supervision models, as the dispensing process would come to a halt without them, with little gain from performing the other 'safe' activities in a pharmacist's absence.

Dispensing process & need for pharmacist involvement/ presence



3.2.3 Views on supervision and accountability, and factors that influence them

Respondents were further asked to agree/disagree (Likert scale) with statements about supervision, which further supported community pharmacists' general reservations and reluctance, with locums being particularly concerned. Again, detailed analysis can be found in the main report, and only a summary of the key findings has been included here.

Views on supervision & accountability – Key points

- There was general agreement by all professional groups that they were confident that pharmacy support staff are competent to perform further activities than they already do when the responsible pharmacist is absent.
- All professional groups agreed that 'now that pharmacy technicians are registered professionals, they should be more accountable for the tasks they perform.'
- While community pharmacists were the most reserved in terms of their agreement with letting pharmacy support staff perform certain activities, they expressed a high level of agreement that 'now that pharmacy technicians are registered professionals, they should be more accountable for the tasks they perform' (90.6%). Comparatively, community pharmacy technicians had only a slightly lower level of agreement with the increased 'accountability' statement (79.6% agreement).
- Whilst a potential difference is recognised (though least by community pharmacists) that professional registration should underpin the extension of pharmacy technician responsibilities (and possibly a differentiation from other support staff), many did not think that the role of pharmacy technicians had indeed changed since GPhC registration was introduced.

Impact of pharmacy and pharmacist/ pharmacy technician characteristics – Key points

For community pharmacists:

- Findings suggest that **familiarity** with the team is an important factor in the level of agreement and perception of risk for the 22 activities.
- **Locum/relief pharmacists** who, due to the nature of their work, may be less familiar with the support team, expressed greater caution about whether or not support staff should perform more activities during a pharmacist's absence.
- However, those locums working regularly at the same pharmacies, who may have greater opportunity to get to know the support team, were less cautious and in this respect more similar to their permanent counterparts.
- Having **experience** was another important factor in terms of, years worked in pharmacy, use of the RP absence and provision of enhanced and advanced services. Less caution was expressed by those with greater experience working in pharmacy and those actually providing some of the services in question, and those with actual experience of using the RP absence.
- **Team composition** also appeared to be important, with again those pharmacists having experience of working with pharmacy technicians and/or accuracy checking technicians (ACTs) expressing greater confidence in the team and less caution about certain activities being carried out during their absence. Having a larger support team also appeared to

enable greater confidence in the competence of the team.

For community pharmacy technicians

- For community pharmacy technicians, being an ACT and working full-time were important factors in the levels of agreement and perception of risk.
- Both ACTs and those working full-time appeared more willing to perform more tasks and take accountability for these activities during a pharmacist absence.
- The size of the support team, experience working in pharmacy and experience of service provision appeared less important for community pharmacy technicians than community pharmacists.

Qualitative analysis of open comments is also presented in the main report, providing further support and insight into the issues explored quantitatively, using pre-determined categories.

3.3 Discussion

This study of supervision in community pharmacy is the first research study to compare and contrast insights from four groups of pharmacy personnel, pharmacists and pharmacy support staff working in community and hospital pharmacy. It thus provides valuable qualitative and quantitative evidence to inform and underpin current developments and consultations into the requirements for pharmacist supervision. Whilst drawing responses from those working in the community sector, hospital pharmacists and pharmacy technicians can usefully inform developments and considerations in community pharmacy. This is based on their experience of skill mix and role delegation, working within a model which commonly involves established models of team working and pharmacist absence from the dispensary.

Consideration will need to be given to the various types of support staff who could (or could/should not) perform certain activities. This report comments on different types of staff, their qualifications, and a need for clear, transparent and consistent levels of qualifications. It further recognises the importance of experience and trust between pharmacy team members, as well as the need for clarity on responsibility and accountability of pharmacists and various other types of support staff, in particular pharmacy technicians.

Key considerations are listed below (and at the end of the main report), with the aim of providing evidence based insights into the complexity of issues which need to be considered carefully when exploring revised models of supervision in community pharmacy.

3.4 Key policy implications and recommendations

Assumption: Responsible Pharmacist (RP) absent, and no other pharmacist present.

- **General support for pharmacists providing more clinical and patient-centred services, enabled by support from appropriately trained, fit for practice and valued pharmacy staff**
- **Pharmacy support staff broadly supportive of pharmacist absence – pharmacists (particularly in community) more cautious**

Pharmacy activities – that could be undertaken during RP absence

- Separate pharmacy activities into: medicines related (OTC sales & dispensing) and service related activities
- Broadly, clinical activities usually require pharmacist supervision and intervention, and technical activities can be undertaken by pharmacy support staff
- General agreement that pharmacy services involving healthy living advice and some public health services can be undertaken by pharmacy support staff
- GSL sales can be undertaken by pharmacy support staff
- P sales by pharmacy support staff require clear standard operating and governance procedures – some may be considered ‘safe’ during a pharmacist’s absence, others not
- Provided a clinical check has been performed prior to a pharmacist’s absence, the remainder of the dispensing process may be possible during a pharmacist’s absence – if clinical advice is either not needed (e.g. for established repeat prescriptions) or the pharmacist is accessible remotely

Pharmacy team – considerations for roles & responsibilities of pharmacy support staff

- Clarity on various support staff qualifications and related competences is important
- Consistency and quality assurance across each type/ level of qualification, particularly registered pharmacy technicians
- Pharmacy technicians’ (and other support staff) abilities and competences need to be understood, recognised and used by pharmacists, but also by pharmacy employers, through appropriate remuneration and career structure, to ensure the most is made of available skill mix
- Competence and skills are important, and these need to be kept up-to-date (revalidation)
- Familiarity of pharmacists with support staff and pharmacy setting. The needs of mobile pharmacists, i.e. locums & relief, may differ from those working in familiar arrangements
- Experience is important to underpin competence, and a minimum number of years’ experience could be required to take on certain activities, particularly during RP absence
- Confidence in support staff is important to enable trust which needs to underpin successful role delegation; this will depend on competence, familiarity and experience.
- Clarity is required on responsibilities and accountability of support staff and pharmacists during a pharmacist’s absence
- Pharmacy technicians, as GPhC registered pharmacy professionals, are the appropriate group of support staff to assume responsibility for a retail pharmacy during the legitimate absence of the RP